Beth Israel Deaconess Medical Center

A teaching hospital of Harvard Medical School

Richard A. Parker, MD
Suite Director

Healthcare Associates
Atrium Suite
General Internal Medicine

Assistant Professor of Medicine

April 11, 2006

Mr. Charles P. Reidy, III
Martin, Magnuson, McCarthy & Kenney
Attorneys at Law
101 Merrimac Street
Boston, MA 02114-4716

RE: Arthur Pernokas v. Barrie Paster, MD

Dear Mr. Reidy,

I have reviewed the case of Mr. Pernokas (DOB 8/15/56) v. Barrie Paster, MD. I will list the records received and reviewed, the chronology of the case and my opinions regarding the standard of care. I charge $450/hr. for review of records, preparation of my report, and any testimony. I will append a list of cases in which I have served as an expert witness in the past four years, and I will append an updated CV that will list all of my publications in the past ten years.

I. Records reviewed

- Medical records of Barrie Paster, MD and the Lahey Clinic
- Medical records of Anna Jaques Hospital
- Medical records of Caritas Holy Family Hospital (Paul Spieler, MD)
- Medical records of Putnam Breed, MD
- Medical records of Stephen Chastain, MD
- Affidavit of Arthur Pernokas
- Deposition transcript of Arthur Pernokas
- Opinion letter of plaintiff expert, Giacomino Biano, MD
- Opinion letter and CV of plaintiff expert, Marcia Browne, MD
- Opinion letter and CV of plaintiff expert, Richard Winickoff, MD
- Deposition of Dianne Pernokas

Carl J. Shapiro Clinical Center
330 Brookline Avenue
Boston, Massachusetts 02215

(617) 667-9600
fax 617-667-6405
raparker@bidmc.harvard.edu

- Interrogatory answers of Dianne Pernokas
- Interrogatory answers of Arthur Pernokas
- Updated medical records of Stephen Chastain, MD through March 27, 2006

II. Chronology

- **12/20/96** – Dr. Paster. Office visit. CPE [complete physical exam]. Wt. 194# FH – adopted. Rectal – prostate not [increased]. [Pt. age 40.]
- **12/20/96** – labs; serum iron 79.9 [70.0-180 microgram/dl] cholesterol 325
- **2/24/97** office visit.
- **3/24/97** office visit
- **6/30/97** office visit
- **9/11/98** office visit "C/o some intermittent bright red rectal bleeding over the past week or two. He has had some episodes in the past. No mucous, diarrhea or abdominal pain. … On anoscopy… internal hemorrhoid at 7 o'clock. A – Internal hemorrhoid. P …Will schedule for flexible sigmoidoscopy."
- **10/14/98** "Used suppositories x 3d with relief of sx. …Flex sig to 55cm. Mult. Tics … Some prominent vessels at 27cm. Small breaks in mucosa at 5cm. Probable source of bleeding. Internal hemorrhoid at 7 o'clock. Dx – Internal hemorrhoid, Diverticulosis."
- **12/8/99** office visit "…c/o abdominal distension and feeling of being bloated with gas. …sometimes relieved by belching or a bowel movement. …drinking heavily. O – Abdomen – soft and nontender. No palpable masses. Will try a week off of the Lopid to see if his abdominal symptoms change."
- **1/6/00** phone call to office. "Still having abd pain with Lopid 300mg bid. Will change to Pravachol 40mg qd. Stressed [decrease] EtOH."
- **6/8/01** Wt. 181.5# S – "He is feeling well." No abdominal complaints are noted.
- **3/14/02** Office visit. Jocelyn Duff, P.A. "…45 year old man who presents with increasing abdominal pain over the last 5-6 days. …no bright red blood or dark tarry stool per rectum. He tells me he has had this intermittently in the past but never quite so severe. …A – Abdominal pain suspect cholelithiasis, rule out appendicitis. P – Discussed with Dr. Breed's office. … he will go to Anna Jaques lab for STAT CBC.
- **3/14/02** Anna Jaques lab – Hct – 27.2, MCV 64.3, CEA 21.5 (0-3.0) CT scan – Large, elongated mass involving the ascending colon…
- **3/14/02** Putnam Breed, MD "45-year-old man is admitted to the hospital for elective right colon resection… He has been bothered by epigastric pain and gas for the past three weeks. … He underwent right ileocolectomy with anastamosis for invasive moderately differentiated adenocarcinoma of the right colon with extension through bowel wall into pericolonic adipose tissue. Mesenteric tumor present in 3 of 14 pericolonic lymph nodes. … Pathologic stage of this tumor was stage 3, T3N1M0.
- **4/1/02** Paul Spieler, MD "… Dukes C-1 carcinoma involving 3 of 16 lymph nodes resected…"

- **5/17/02** Paul Spieler, MD "He began chemotherapy with Leucovorin, 5FU about a month ago…"
- **2/7/03** Office visit – Paul Spieler, MD "…c/o 2 months of severe anal pain…"
- **2/26/03** William Jackson, MD Colonoscopy. "he did have marked hemorrhoidal disease. … no lesions seen."
- **3/18/03** Lahey Clinic. Office visit. Peter Marcello, MD. "…c/o severe anal pain… He occasionally would see blood on the tissue…. Perianal inspection shows evidence of a chronic anal fissure… There is minor engorgement of external hemorrhoidal tissue.
- **4/15/03** Peter Marcello, MD. "There has been less bleeding."

III. Opinions

1. At the 9/11/98 visit, Mr. Pernokas, then 42 years old, presented with occasional bright red blood per rectum (BRBPR). This is a common symptom in this age group. Dr. Paster met the standard of care by performing an anoscopy that revealed an internal hemorrhoid. He also met the standard of care by scheduling a flexible sigmoidoscopy to look for any other source of BRBPR. In a 42-year-old man, the most likely source of BRBPR is hemorrhoids or diverticular bleeding.

   Bright red blood per rectum almost always emanates from the distal colon, well within the view of the flexible sigmoidoscope. The exception to that is when bleeding from the proximal colon or small bowel is very rapid. This uncommon but more serious situation usually results in major blood loss, hypotension or shock. Mr. Pernokas did not manifest signs or symptoms reflecting such a major degree of blood loss. On the day of the sigmoidoscopy, 10/14/98, Dr. Paster's note states that Mr. Pernokas "used suppositories x 3d with relief of symptoms." Mr. Pernokas in his deposition, p. 41, when asked if the bleeding had continued, he stated, "Yes, but it was waning." It is my opinion that he appeared to be a typical patient with hemorrhoidal bleeding. More likely than not, hemorrhoids were the cause of bleeding at that visit.

   Dr. Paster met the standard of care by performing a sigmoidoscopy. The findings of internal hemorrhoid, prominent vessels at 27cm. and diverticuli reasonably explained the source of bleeding. The standard of care did not require a colonoscopy or barium enema or any other diagnostic testing.

2. Screening for colon cancer is not indicated until age 50 unless there is a known family history of colon cancer. Dr. Paster obtained the history that Mr. Pernokas was adopted, and thus no useful family history was available to him. When no family history is available as in this case, the default position statistically is that the family history is non-contributory to the assessment of risk.

3. The routine checking of a complete blood count (CBC) is *not indicated* by the U.S. Preventive Services Task Force in men in their 40s as a screening test for anemia or cancer.

4. In Mr. Pernokas' office visits, he did not present complaints that were typical of colon cancer of the proximal colon, such as change in bowel habits or constipation. His alcoholism also complicated his history, as vague abdominal complaints are typical in alcoholic patients. Specifically, in the office visit of 12/8/99, Mr. Pernokas complained of "some abdominal distension and feeling of being bloated with gas. ...it is sometimes relieved by belching or a bowel movement." In a 43 year old man who is admitting to drinking six to ten beers per day, this would be the leading cause of the symptoms. At the 1/6/00 phone call, it was reasonable for Dr. Paster to suggest changing from Lopid to Pravachol in an attempt to decrease his abdominal discomfort. Common side effects of Lopid include abdominal pain, dyspepsia and flatulence.

5. At the 6/8/01 office visit, Mr. Pernokas states that "he is feeling well." There are no complaints recorded in this visit to suggest the diagnosis of colon cancer.

6. Between the 6/8/01 office visit and the next visit on 3/14/02 – an interval of nine months, Mr. Pernokas made no office visits. This suggests that he was not significantly symptomatic, or if he was symptomatic, he chose not to visit the doctor.

7. After the 1/6/00 phone call until 3/14/02, the chart does not show any visits or phone calls with complaints of abdominal pain – an interval of 2 years and 2 months. It is highly improbable that a patient with significant abdominal symptoms as is alleged by the plaintiff, would make no phone calls or office visits to alert the physician to these symptoms.

8. Mr. Pernokas stated in his deposition (pp. 45-46) that though he had occasional rectal bleeding after October, 1998, he himself attributed it to hemorrhoids, and did not bring it to Dr. Paster's attention. In my opinion, Mr. Pernokas was correct that his overt bleeding was always secondary to hemorrhoids, and was never connected to the proximal colon cancer.

9. Mr. Pernokas stated in his deposition (pp. 16-17) that he continued to have rectal bleeding *after* his cancer surgery. This reflects a pattern of BRBPR and supports my opinion that the original bleeding that was reported on 9/11/98 was unrelated to the colon cancer.

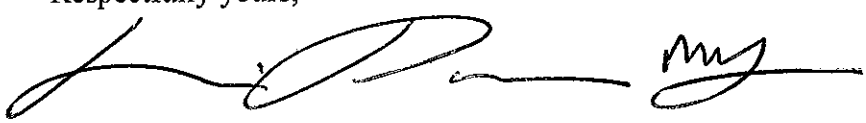
10. In my opinion, the weight loss that Mr. Pernokas experienced from 1996 to 2001 was not related to his colon cancer. The ideal weight for a man 6 feet tall ranges from 150# to 188# depending on frame size. The records show that he weighed 194# on 12/20/96 and 181 ½ # on 6/8/01. Mr. Pernokas stated in his deposition (pp. 30-33) that he himself was not particularly concerned about his weight loss. For a patient such as Mr. Pernokas who was approximately 6 feet tall and

weighed in the 190s, it is common for an individual's weight to vary by 10-12 pounds, and does not in and of itself constitute a cause for concern

11. Proximal right-sided colon cancers usually present with constipation or change in bowel habits, anemia, or trace blood in the stool on screening guiac tests. Colon cancers located in the very proximal right colon as in Mr. Pernokas' case do not cause BRBPR unless they are bleeding extremely rapidly, which is highly unusual. *If* the cause of bleeding in September, 1998 was secondary to a colon cancer, more likely than not, it would have continued to bleed significantly in the months that followed. There is no such history of this. It is my opinion with a reasonable degree of medical certainty that Mr. Pernokas' BRBPR was secondary to his known hemorrhoids.

12. It is my opinion that at all times Dr. Paster met the standard of care for the average qualified internist with regard to Mr. Arthur Pernokas. There is nothing that Dr. Paster did or did not do that contributed to the timing of Mr. Pernokas' diagnosis or his ultimate prognosis.

Respectfully yours,



Richard A. Parker, MD